Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jedetta Green, ANP,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-305

Decision No. CR2567

Date: July 13, 2012

DECISION

Jedetta Green, (Petitioner), appeals a reconsideration decision issued on November 30, 2011. I grant summary judgment and sustain the determination of the Centers for Medicare and Medicaid Services (CMS) finding that the undisputed evidence establishes CMS properly enrolled Petitioner in the Medicare program effective July 15, 2011.

I. Background and Procedural History

Petitioner is a nurse practitioner employed by Providence Health & Services in Anchorage, Alaska. Petitioner sought to become enrolled in the Medicare program and to reassign her right to bill for services, so she submitted an enrollment application, CMS Form 855I. CMS Exhibit (CMS Ex.) 1. Noridian Administrative Services (Noridian), a CMS contractor, received Petitioner's enrollment application on July 15, 2011. CMS Ex. 6, at 1. By letter dated August 9, 2011, Noridian notified Petitioner that her Medicare enrollment application had been approved effective June 16, 2011.[1] CMS Ex. 3.

[1] Noridian erroneously characterized June 16, 2011 as Petitioner's "effective date" rather than Petitioner's retrospective billing date. In Petitioner's situation, the contractor must assign the date of receipt of the application as the effective date of Petitioner's enrollment

Petitioner timely requested reconsideration of the initial decision and requested that her effective enrollment date be changed to January 24, 2011. CMS Ex. 4. On November 30, 2011, a contractor hearing officer issued a reconsideration decision denying Petitioner's request for an earlier effective date of enrollment.[2] CMS Ex. 5, at 1-3.

Petitioner then filed a hearing request with the Civil Remedies Division of the Departmental Appeals Board, and the case was assigned to me for hearing and decision. In accordance with my Acknowledgment and Pre-hearing Order issued on January 26, 2011, CMS filed a Motion for Summary Judgment and supporting brief (CMS Br.), accompanied by six exhibits (CMS Exs. 1-6), on February 29, 2012. Petitioner did not respond to the CMS Motion for Summary Judgment, and I subsequently issued an Order to Show Cause on April 23, 2012. On May 7, 2012, Petitioner responded to my Order to Show Cause by letter (P. Response) and explained that "[the Petitioner does] not dispute the facts set forth in the CMS Motion and . . . would like for you to decide this case based upon the written record of all documents previously submitted." Petitioner also stated "[p]lease accept my apology for not filing the pre-hearing exchange in accordance with your . . . order. It was not evident to me that I should file an exchange." In the absence of objection, I admit CMS Exs. 1-6 into the record.

II. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare beneficiaries may only be made to eligible providers of services and suppliers.[3] Act

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while permitting the contractor to grant retrospective billing privileges for 30 days prior to the effective date. 42 C.F.R. § 424.521(a)(1). The February 28, 2012, Declaration of Gina LaCroix, a Provider Enrollment Representative at Noridian explains this. CMS Ex. 6.

[2] The Declaration of Gina LaCroix also explains that the November 30, 2011, reconsideration decision contained a typographical error. CMS Ex. 6, at 2. In the reconsideration decision, Ms. LaCroix determined that Noridian correctly reported that Petitioner's application had been received on July 15, 2011, but Noridian inadvertently typed the "effective date" as June 6, 2011. CMS Ex. 6, at 2, CMS Ex. 5, at 1. Ms. LaCroix explains that this was a "typo, and should have been 'June 16' which is consistent with the . . . original notification letter of August 9, 2011." CMS Ex. 6, at 2.

[3] A "supplier" furnishes services under Medicare, and the term supplier applies to physicians and other non-physician practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). Nurse practitioners and other non-physician practitioners are considered suppliers under the relevant regulations. *See* 42 C.F.R. §§ 400.202 and 424.502.

§§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). The Act requires the Secretary of Health and Human Services to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

A supplier must be enrolled in the Medicare program and be issued a billing number to be eligible to receive direct payment from Medicare for services rendered to its beneficiaries. 42 C.F.R. § 424.505. The effective date of enrollment for a supplier may only be the later of two dates: (1) the date when the supplier filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or (2) the date when the supplier first began providing services at a new practice location. 42 C.F.R. § 424.520(d). The date of filing of the enrollment application is the date when the designated Medicare contractor receives the complete enrollment application and supporting documentation. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008).

Additionally, an enrolled supplier may bill for services provided to Medicare eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. 42 C.F.R. § 424.521(a)(1). Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in the case of a Presidentially-declared disaster. 42 C.F.R. § 424.521(a)(2).

III. Analysis

A. Issue

The issue in this case is whether CMS's contractor and CMS had a legitimate basis for determining Petitioner's effective Medicare enrollment date, and retrospective billing date, for Medicare billing privileges.

B. Applicable Standard For Summary Judgment

Board Members of the Appellate Division of the Departmental Appeals Board (the Board) stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the

> non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted).

The role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

C. Finding of Fact and Conclusion of Law

1) CMS's contractor and CMS properly determined Petitioner's effective date of Medicare enrollment.

The relevant facts are not disputed, and I draw all reasonable inferences in favor of Petitioner. Petitioner began providing services to Medicare beneficiaries in January of 2011. CMS Ex. 4. Petitioner subsequently submitted a Medicare enrollment application to Noridian. CMS Ex. 1. Noridian received Petitioner's Medicare enrollment application, which was eventually approved, on July 15, 2011. On August 9, 2011, Noridian approved Petitioner's enrollment application with an effective date of July 15, 2011 and retrospective billing privileges commencing on June 16, 2011. CMS Ex. 3.

Petitioner contends that her effective date of enrollment should be January 24, 2011, the date she began rendering services to Medicare beneficiaries. Petitioner does not deny that CMS received her enrollment application on July 15, 2011. However, Petitioner argues that her effective date should be earlier because:

> This enrollment was later due to a breakdown in communication between our clinic and business office. [Petitioner] started her employment in 2010 as an RN and transitioned to providing billable services after she was licensed as a Nurse Practitioner. Because she was already employed, the enrollment and reassignment of Medicare benefits process was overlooked in error. [Petitioner] actually treated numerous Medicare Beneficiaries during the months from January until June when the oversight was discovered and her initial applications were submitted. We are
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> respectfully asking for a retroactive effective date to bill for services that were performed in good faith and for the benefit of many Medicare

> Beneficiaries.

CMS Ex. 4.

The effective date of Medicare enrollment and billing privileges is dictated by 42 C.F.R. § 424.520(d). The regulation provides:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Emphasis added).

The effective date for Medicare billing privileges is determined according to the later of the two dates specified by the regulation. The "date of filing" is the date that the Medicare contractor receives a signed enrollment application that the Medicare contractor is able to process to approval. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). Because it is undisputed that the contractor received Petitioner's approvable enrollment application on July 15, 2011, which is after the date Petitioner began providing services, the regulation dictates that this is the effective date of Petitioner's enrollment.

2) I am unauthorized to grant Petitioner's requests for equitable relief despite not meeting the legal requirements for Medicare enrollment.

Petitioner made various arguments for equitable relief at the reconsideration level and during this appeal. Petitioner's arguments for not meeting the legal requirements of enrollment pertain to administrative errors made during the enrollment process, a breakdown in communication between Petitioner's clinic and business office, and the fact that Petitioner provided services to Medicare beneficiaries for several months prior to her enrollment in good faith and for the benefit of Medicare beneficiaries. CMS Ex. 4. I am not without sympathy for Petitioner's predicament. Petitioner did not argue, however, that she filed a complete application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the regulatory criteria.

I am without authority to order either Noridian or CMS to provide an exemption to Petitioner under the regulations set forth at 42 C.F.R. §§ 424.520(d) and 424.521(a), which are binding on me. I cannot alter or deviate from the regulations' explicit

limitation on Petitioner's ability to bill for services up to 30 days prior to the date Noridian received Petitioner's complete application. Also, I have no authority to extend the retrospective billing period for Petitioner in this circumstance or ignore the clear requirements of the regulations governing her enrollment in Medicare. *Id*. Even accepting all of Petitioner's assertions as true, Petitioner's equitable arguments give me no ground to grant Petitioner an earlier effective date of enrollment. *See US Ultrasound*, DAB No. 2302, at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). Moreover, I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground."). Thus, I have no authority to change Petitioner's Medicare enrollment date based upon equitable considerations.

I conclude that Petitioner's effective date of Medicare enrollment was July 15, 2011, the undisputed date on which she submitted an enrollment application that could be processed to approval. Petitioner was also properly authorized to bill Medicare for services provided to Medicare beneficiaries as of June 16, 2011, or 30 days prior to her effective date of enrollment, which is the maximum amount of retrospective billing permitted under the relevant regulations. Accordingly, I grant summary judgment in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge